**History Taking 2 - Consultation Skills**

**List of Consultation Skills**

Greetings and introductions

Open question

Active listening (non-verbal - eye contact, nodding, encouraging gestures; verbal – agreement `yes’, `go on…’ `aah ha’, summarising back story to patient, clarification of story)

Screening question `anything else?’ + agenda setting (prioritising problems and negotiating the agenda with the patient)

Negotiating the agenda

Open to closed questions

Clarification

Picking up cues

Exploring patient perspective (FIFE – Patient Feelings, Ideas, Fears and Expectations OR ICE – Patient Ideas, Concerns and Expectations)

Summarisation

Signposting

**Scenario 1 Student Doctor**

You are a fourth year medical student at Prince Hamza hospital and you are asked to see a male patient Mohammad who has just arrived in the waiting room. Introduce yourself, check the patient’s ID and greet him. Then begin the consultation and discover what the patient’s problem is. After listening well choose some closed questions to ask more about the problem then explore the patient’s worry and expectation.

**Scenario 1 Male Patient**

Name: Mohammad Darwish

Age: 68 years old

Occupation: Retired Ministry of Labour worker

Address: Tababour

Marital status: Married with 8 children

*PC:* Started with right leg pain over the last 6 months

*HPC:* Started gradually in right calf and now getting more frequent

Like an ache in back of calf

Severity 7/10 pain scale

Comes on when walks fast or long distance – manages about 200-300metres before it comes on

Goes when stops walking

No other associated symptoms

*Cue:* `I’m worried about losing my leg’

*Patient concern (if asked):* I’m worried about losing my leg because an uncle started with calf pain and ended up having gangrene in his feet and having a below knee amputation

*Patient expectation:* Hoping you will examine him, do some tests and reassure him that there isn’t any risk of losing his leg

*Patient ideas:* Thinks it’s just muscle cramps

PMH: Previous Myocardial Infarction 2008

Hypertension 2006

DH: Aspirin 100mg

Bisprolol 5mg

Lisinopril 5mg

SH: Smokes 2 packets a day since the age of 18 years

**Scenario 1 Facilitator's Discussion Points**

*Summarisation:* **Can they summarize the history?**

*General Feedback:* **What went well? What did they demonstrate well? What didn’t go so well? What could they focus on for next and practice?**

**How did the student introduce themselves and greet the patient?**

**What was the opening question the student asked? Are there alternative questions you could ask?**

**What active listening skills did the student display?** e.g. how long was it before the student doctor interrupted the patient? (non-verbal - eye contact, nodding, encouraging gestures; verbal – agreement `yes’, `go on…’ `aah ha’, summarising back story to patient, clarification of story)

**When considering the diagnosis what about the patient lifestyle may be contributing to their leg pain?** (Smoking risk factor for peripheral vascular disease)

*Patient perspective:* **Did they pick up the verbal cue? `I’m worried about losing my leg’**

**What questions did they use to explore the patient’s ideas, concerns and expectations or feelings about this problem?**

Ideas: Had you any thoughts about what you think is going on? Have you spoken to anybody about what you or they think is going on?

Concerns: Is anything particularly you are worried about? What concerns you about this pain? What is your biggest worry about this pain?

Expectations: What were you thinking I could do for you today about this problem? Had you any thoughts about the next step with this problem?

Feelings: How do you feel about this problem? How is this problem making you feel? Some people when they get pain like this may get down or frustrated is this something you are feeling at the moment?

**Scenario 2 Student Doctor**

You are a 4th year medical student at Prince Hamza hospital and you are asked to see a 57 year old male patient named Marwan who has just arrived in the emergency room. Introduce yourself, check the patient’s ID and greet him. Then begin the consultation and discover what the patient’s problem is by taking a thorough medical history. At the end summarize back to the patient the history in their own words.

**Scenario 2 Male Patient**

Name: Marwan

Age: 57 years old

Address: Amman

Occupation: Works as a teacher

Marital status: Married with 3 kids

Presenting Complaint: central abdominal pain

No radiation, started gradually and is worsening

Intermittent and crampy

Worse by eating and drinking and relieved by vomiting

Severity 6/10

Associated symptoms if asked directly: Nausea, Vomiting, Constipation, and Weight loss

If asked directly: No fever or radiation

Verbal cue: Look worried and say *`do you think it is anything serious?’*

If doctor asks you why you think it is serious say: *You are worried it may be something serious as this is how you presented 10 years ago when you needed surgery for bowel cancer*

Medications: None

Allergies: None

Past medical history: 2007 colon cancer

Past surgical history: 2007 Partial colectomy (remove part of colon)

Family history: Father passed away due to colon cancer/ has 2 brothers and 1 sister who are all healthy

Social history: Smokes 30 cigarettes daily since aged 17 years

**Facilitator’s Notes Scenario 2 – Bowel Obstruction with Previous Colonic Cancer**

*Summarisation:* **Can they summarize the history?**

**Is there any more information you would like to know (or does anyone else want to know)?**

**What active listening skills did you use in taking this history? How long was it before the doctor interrupted the patient?**

**What was the patient concern in the consultation? Did you pick it up? How if not what was the verbal cue?** (Cue in dialogue: `Is it something serious?')

**What specific closed pain questions did you use after your open question?**

(Specific pain questions: site, onset, character, severity (use pain scales out of 10?), radiation, timing (duration, course, pattern), exacerbating and relieving factors, associated symptoms)

**What diagnosis do you think this man might have (extra information – non-essential)?**

(The history is suggestive of bowel obstructive symptoms – worsening abdominal pain with vomiting and constipation)

**How many pack years of smoking does this man have?**

30cig’s a day / 20 \* 40years = 60 pack years

**Scenario 3 Student Doctor Instructions**

Heba Massad is a 22-year old female coming to your clinic for the first time.

Greet the patient, introduce yourself, and obtain the patient’s profile.

Ask an opening question and afterwards ask `Is there anything else?' and then set the agenda for the consultation. Explore the patient’s perspective about this problem.

**Scenario 3 Female Patient's History**

Name: Majda Massad

Age: 22

Occupation: Worked at Carrefour, but quit job last month

Address: Fuheis

*Presenting Complaints:* You have multiple problems including headaches, feeling stressed, pain in your whole body, tiredness and feeling sick.

If asked what your MAIN complaint is, it is feeling stressed all the time.

It started two months ago after your aunt died.

You quit your job and only leave the house once per week as you’re anxious

You also have difficulty sleeping and have `too many thoughts’

You have gained 5 kilos in the last 2 months.

Patient cue: `You’re worried you are going mad’

If the student asks to clarify what the patient means. `Well my aunt had schizophrenia and she committed suicide 2 months ago. I’m worried I might have something like she had.’

Patient concern: As above. (No visual or auditory hallucinations, paranoid thoughts or suicidal thoughts)

Patient expectation: Wants reassurance she isn’t going mad

Patient idea: Not sure but wonders if all these multiple physical symptoms might be stress.

*PMSH:* No past medical or surgical problems

*Drug History:* 6 Brufen pills every day for the headaches, No allergies

*Family History:* Your parents and siblings are all healthy.

*Social History:* Started drinking a small glass vodka to try and sleep better

**Scenario 3 Facilitator's Discussion Points**

*Summarisation:* **Can they summarize the patient history?**

*General Feedback:* **What went well? What did they demonstrate well? What didn’t go so well? What could they focus on for next and practice?**

*Specific Feedback:* **How did the student introduce themselves and greet the patient?**

**What was the opening question the student asked?**

**How did the student doctor show active listening skills?**

**How did the student set the agenda?** List all the problems and prioritise which one to talk about – how should doctors prioritise multiple problems patients present with?

**What possible diagnoses would you consider for this lady?** (Anxiety and depression, medical problems including hypothyroidism, adrenal disease. Need to explore other psychological and psychiatric symptoms and perform a suicide risk)

**What about the patient’s concern about possible madness?** What does this mean? Clarification is a consultation skill to determine meaning of patient’s words – what is that experience for the patient and what is their framework of reference e.g. do they mean a spiritual thing like `jinn’ or the `hesed’ or are they worried about schizophrenia – expect to see other symptoms e.g. paranoia, delusions, visual or auditory hallucinations.

**How did the student explore the** patient’s perspective? What were the patient’s ICE or FIFE? What questions did they use?

**How many units is a measure / small glass (25ml) of whisky?** 1 unit of alcohol. Need to clarify what a small glass is when the patient describes this??

**Scenario 4 Student Doctor**

You are in an UNWRA clinic in Rusayfah.

Your next patient is Dareen who is 25 years old

Introduce yourself, greet the patient and begin the consultation.

Discover the reason for the patient’s attendance, what they are concerned about and summarise the patient’s problem back to the patient afterwards.

**Scenario 4 Female Patient**

Name: Dareen Metani

Age: 37 years old

Occupation: Housewife looks after 3 children

Address: Mafraq

Marital status:Married with 3 children – had third child 2 months ago

You are struggling to cope with your 3 children at home and your husband works long hours at the nearby factory.

You feel very dizzy whenever you stand up.

You feel tired and no energy to prepare the family food.

You had a difficult labour 2 months ago and lost a lot of blood during the delivery.

Patient Concern: You have a family history of thyroid problems and are worried this is a possible cause.

Patient Feelings: Upset and tearful `struggling to cope’

Patient Expectation: Hoping the doctor will do a blood test today to check whether it is a thyroid problem

PMSH: You have no previous medical history

DH: Not taking any medications, no allergies

FH: Mother and aunt had Hypothyroidism and takes medication

SH: Doesn’t drink alcohol or smoke

**Scenario 4 Facilitator Discussion Points**

*Summarisation:* **How was the student doctor’s summary of the history?** (Why is summarising the story back to the patient a helpful skill? Shows active listening, clarifies you have heard the story correctly and allows you time to formulate your next question)

*General Feedback:* **What went well? What did they demonstrate well? What didn’t go so well? What could they focus on for next and practice?**

*Specific Feedback:* **What was the opening question the student asked?**

**How did the student doctor show active listening skills?** Non-verbal - eye contact, nodding, encouraging gestures. Verbal – agreement `yes’, `go on…’ `aah ha’, summarising to patient, clarification of story

**When considering the diagnosis what about the patient profile may be contributing to their dizziness and tiredness?** *(Postnatal – risk for anaemia and thyroid disease)*

**Clarification question – consultation skill** `What does the patient mean by dizziness?’ What specific closed questions would help differentiate the different medical possibilities for her dizziness? Is it dizziness due to anaemia or vestibular problem e.g. what do you mean by dizziness? Is it like the room spinning around or is it like a lightheaded feeling?

**What questions did they use to explore the patient’s ideas, concerns and expectations or feelings about this problem?**

Ideas: Had you any thoughts about what you think is going on? Have you spoken to anybody about what you or they think is going on?

Concerns: Is anything particularly you are worried about? What concerns you about this pain? What is your biggest worry about this pain?

Expectations: What were you thinking I could do for you today about this problem? Had you any thoughts about the next step with this problem?

Feelings: How do you feel about this problem? How is this problem making you feel? Some people when they get pain like this may get down or frustrated is this something you are feeling at the moment?

Don’t forget need to screen for postnatal depression or puerperal psychosis in this situation so enquiring about feelings is important.